VERMONT

State of Vermont
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Agency of Human Services

☐ Rental Wheelchair Evaluation and Prescription Form
☐ Basic Wheelchair Purchase Evaluation and Prescription Form

- Complete every line of this form to avoid delays and denials.

Date: ___/____/_____ Beneficiary Name: _____DOB: ___/____/_____

Therapist name (print): _____Therapist Signature: _____

Therapist Phone Number: _____ Therapist Email: _____

Insurance(s): _____

Discharge date from inpatient facility (if applicable): ___/____/_____

Medical Conditions (include onset dates): _____

Height: _____ Weight: _____

Estimated length of need: _____Weight bearing status:_____

Bed Mobility: _____

Transfer technique: _____

Ambulation (distances, devices, assist): _____

Propulsion technique (specify equipment, limbs used): _____

Home accessibility- include ingress/egress and accessibility to bathroom and bedroom:

_____

Seat width needed: _____Seat length needed: _____

Type of chair needed (check one) — **Medical necessity rationale**:

- ☐ Pediatric _____
- ☐ Standard _____
- ☐ High strength lightweight _____
- ☐ Lightweight _____
- ☐ Heavy duty _____
- ☐ Extra heavy duty _____
- ☐ Ultralightweight (rental only) _____
- ☐ Power (specify group: ___) (rental only) _____

Type of accessories needed (check all appropriate) — **Medical necessity rationale:**

- ☐ Semi reclining _____
- ☐ Fully reclining _____
- ☐ Tilt in space _____
- ☐ Detachable armrests _____
- ☐ Elevating leg rests _____
- ☐ Anti-tippers _____
- ☐ Cushion (specify general, skin protection, positioning): _____
- ☐ Other _____

Assessment: (You may also attach clinic note and supporting documentation):

_____